Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HOUSTON NORTHWEST MEDICAL CENTER
C/O LAW OFFICE OF P MATTHEW ONEILL
6514 MCNEIL DR BLDG 2 STE 201
AUSTIN TX 78729

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-98-7444-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary in the request for medical dispute resolution package.

Amount in Dispute: $7941.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…The Fund also contends that Petitioner's evidence fails to meet Petitioner's burden of proof to establish by a preponderance of the credible evidence that the Funds' reimbursement methodology falls short of the statutory standards for payment set forth above…Further, independent evidence established that the payment method used by the Fund provides payment to hospitals that equaled or exceeded the payment levels set in the statutory standards."

Response Submitted by: TWCIF, 221 West 6th Street, Suite 300, Austin, TX 78701-3403

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
September 2, 1997 through September 5, 1997	Inpatient Hospital Services	$7941.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the

procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 TexReg 6264, sets out the reimbursement guidelines for inpatient hospital services.
3. Former 28 Texas Administrative Code §134.1(f) effective October 7, 1991, 16 *Texas Register* 5210, sets out the reimbursement guidelines for the services in dispute.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. This request for medical fee dispute resolution was received by the Division on September 30, 1997.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - M-Reimbursed according to fair and reasonable standards.
   - F-Included as fair and reasonable for inpatient services according to the Texas Hospital Inpatient Fee Guideline per diem rate.
   - F-Pharmaceuticals administered during the admission and or grater than $250 charged per dose shall be reimbursed at cost plus 10% per the Texas Aucte Care Inpatient Hospital Fee Guideline, page 70.
   - F-Reimbursed in accordance with the Texas Hospital Inpatient Fee Guideline.

Findings

1. This dispute relates to inpatient medical services provided in a hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.401.
2. 28 Texas Administrative Code §134.401(b)(1)(B), states "Inpatient Services – Health care, as defined by the Texas Labor Code §401.011(10), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute care hospital."

   A review of the submitted medical bill and itemized statement, indicate that the requestor billed for three (3) inpatient surgical day; therefore, this admission meets the definition of inpatient services per 28 Texas Administrative Code §134.401(b)(1)(B).
3. 28 Texas Administrative Code §134.401(c)(1) states "Standard Per Diem Amount. The workers' compensation standard per diem amounts to be used in calculating the reimbursement for acute care inpatient services are as follows: Surgical $1,118."
4. 28 Texas Administrative Code §134.401(c)(3)(B), the reimbursement calculation formula is "LOS X SPDA = WCRA." Therefore, 3 days multiplied by $1,118.00 = $3,354.00.

   A review of the submitted EOB supports reimbursement of $3354.00 for inpatient surgical services; therefore, the requestor was paid in accordance with 28 Texas Administrative Code §134.401(c)(1) and (c)(3)(B).
5. 28 Texas Administrative Code §134.401(c)(4)(B), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate: (iv) Blood (revenue codes 380-399."

   The Division finds that the requestor billed revenue code 390 for Blood/Stor-Proc at $160.00.

   A review of the submitted EOB supports reimbursement of $99.20 for Blood/Stor-Proc was made based upon fair and reasonable reimbursement.
6. Review of the submitted documentation finds that:
   - The requestor did not submit a position statement for consideration in this dispute.
   - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
   - The requestor does not discuss or explain how payment of the amount sought would result in a fair and reasonable reimbursement for the services in this dispute.
   - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement for the disputed services.
   - The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for revenue code 390. Additional payment cannot be recommended.
7. 28 Texas Administrative Code §133.305(d)(7), effective June 3, 1991, 16 *Texas Register* 2830, requires that the request shall include "copies of all written communications and memoranda relating to the dispute." Review of the documentation submitted by the requestor finds that the request does not include any copies of

explanation of benefits, medical records or other written communications and memoranda pertinent to the dispute. The Division concludes that the requestor has not met the requirements of §133.305(d)(7).

8. 28 Texas Administrative Code §133.305(d)(9), effective June 3, 1991, 16 *Texas Register* 2830, requires that the request shall include "copies of all medical bills, which are disputed, as originally submitted to the insurance carrier." Review of the documentation submitted by the requestor finds that the request does not include a copy of medical bills. The Division concludes that the requestor has not met the requirements of §133.305(d)(9).
9. 28 Texas Administrative Code §133.305(d)(10), effective June 3, 1991, 16 *Texas Register* 2830, requires that the request shall include "a summary of the requesting party's position regarding the dispute." Review of the documentation submitted by the requestor finds that the request does not include a summary of the requesting party's position regarding the dispute. The Division concludes that the requestor has not met the requirements of §133.305(d)(10).

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under 28 Texas Administrative Code §133.305. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	11/22/2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.